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I.V. Withdrawal: The Severance of Medicine's or Society's Umbilical Cord? *Barber v. Superior Court of Los Angeles County*, 137 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983)

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I.V. Withdrawal: The Severance of Medicine’s or Society’s Umbilical Cord?

Barber v. Superior Court of Los Angeles County, 137 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983)

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Death Destroys a Man, But the Idea of Death Saves Him.
—Edwin Morgan Forster

I. INTRODUCTION

On the morning of August 29, 1981, Clarence Herbert lay comatose in his sterile hospital room attached to life-support equipment.¹ At 9:15 that morning, Neil Barber, M.D. (the internist to the

1. Memorandum of Points and Authorities with Statement of the Case Supporting Defendant’s Motion to Dismiss at 7, *People v. Barber*, No. A 025 586 (Cal. L.A. Mun. Ct. 1983) [hereinafter cited as Defendant’s Brief].

patient's surgeon, Robert Nejd, M.D.) disconnected Mr. Herbert's respirator in the presence of the patient's wife, and had the moisture to the endotracheal tube² turned off.³ Mr. Herbert's life did not end with the withdrawal of the respirator. He continued to breathe. The family steadfastly awaited his death. Fearing it would disturb Mr. Herbert, the family refused to allow the nurses to provide the care routinely given to comatose patients.⁴ Two days after the removal of the respirator, Dr. Barber, with the family's consent, withdrew the intravenous feeding and hydration tubes. Mr. Herbert was pronounced dead six days later.⁵ The Los Angeles County Prosecutor charged Doctors Nejd and Barber with murder and conspiracy to commit murder.

The case ran its judicial course through three California courts.⁶ Judge Crahan of the Los Angeles Municipal Court dismissed the charges after a preliminary hearing on the basis that there was no evidence that the doctors' actions were the proximate cause of death, and the prosecution did not offer sufficient evidence to demonstrate that the steps taken by the doctors were intended to mask or mitigate damages attributable to malpractice.⁷ The Superior Court of Los Angeles County overruled the dismissal and reinstated the criminal complaint:⁸ "In view of the public interest in this case, the court wants to point out that at this point in the proceedings the prosecution need only show a strong suspicion of guilt."⁹ Judge Wenke stressed that the pretrial hearing did not

2. An endotracheal tube is a plastic tube extending outside the nose or mouth down past the vocal cords and is used to maintain the patient's airway. 5 A LAWYERS' MEDICAL CYCLOPEDIA § 33.9 (C. Frankel & R. Patterson rev. ed. 1972).

3. The air mist to the endotracheal tube was terminated five minutes after the respirator was disconnected. The prosecutor stated that this act was intended to facilitate the accumulation of mucus to block Mr. Herbert's airway, but a concerned nurse had the air mist restarted before this could occur. Prosecution's Points and Authorities for Preliminary Hearing at 8, *People v. Barber*, No. A 025 586 (Cal. L.A. Mun. Ct. 1983) [hereinafter cited as Prosecution's Brief].

4. The family repeatedly told members of the nursing staff that they wanted all treatment to be stopped. On one occasion, the simple addition of potassium to Mr. Herbert's I.V. made the family quite upset, and prompted one of Mr. Herbert's sons to scream the prescribing physician's name repeatedly. Defendant's Brief, *supra* note 1, at 7-9.

5. Prosecution's Brief, *supra* note 3, at 9.

6. *People v. Barber*, No. A 025 586 (L.A. Mun. Ct. 1983) (criminal complaints dismissed after preliminary hearing); *People v. Barber*, No. A 025 586 (Cal. L.A. County Super. Ct. 1983) (complaints reinstated); *Barber v. Superior Court*, 137 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (vacated Superior Court's reinstatement of complaints and denied people's motions).

7. *People v. Barber*, No. A 025 586, at 10 (Cal. L.A. Mun. Ct. 1983).

8. *People v. Barber*, No. A 025 586 (Cal. L.A. County Super. Ct. 1983).

9. *Id.* at 4.

reveal whether the patient's coma was irreversible—a necessary condition for termination of life-sustaining measures under California law¹⁰—which, considering the bifurcated positions, must be established at a trial on the merits. The California Court of Appeals upheld the Municipal Court's dismissal.¹¹ Relieved by the appellate court's decision, Nejd and Barber returned to their vocations. The medical profession applauded the decision as one that would relieve the medical community from criminal liability in such situations.¹² However, the language of the decision presents serious doubt to the validity of such an interpretation. The court emphasized that a doctor who had acted with precipitous motives would be criminally liable for the patient's death.¹³

The issue of continued treatment for comatose or vegetative patients has been addressed by courts¹⁴ and commentators¹⁵ alike. The narrower issues of whether nourishment and hydration are in fact treatment, and whether physicians should be held criminally liable in these situations, have seldom been addressed.¹⁶ While *Barber* is the first major decision of its kind,¹⁷ its solitude does not reflect the frequency of such situations.¹⁸

10. *Id.*

11. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

12. See AMERICAN MEDICAL NEWS, Oct. 28, 1983, at 1.

13. "For the purposes of this decision, however, we accept the superior court judge's analysis that if petitioners unlawfully and intentionally killed Mr. Herbert, the malice could be presumed regardless of their motive." *Barber v. Superior Court*, 137 Cal. App. 3d 1006, —, 195 Cal. Rptr. 484, 487 (1983).

14. See *infra* notes 29-52 and accompanying text.

15. In addition to the many commentators noted throughout this Article, see generally M. MANNES, *THE RIGHT TO DIE: SHOULD THERE BE A LAW?* (1973); G. WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* (1957); EUTHANASIA AND THE RIGHT TO DEATH: THE CASE FOR VOLUNTARY EUTHANASIA (A. Downing ed. 1969); *THE MOMENT OF DEATH: A SYMPOSIUM* (A. Winter ed. 1969); *YOUR DEATH WARRANT?* (J. Gould & L. Craigmyle eds. 1971); *BENEFICIENT EUTHANASIA* (M. Kohl ed. 1975).

16. See *infra* notes 60-69 and accompanying text.

17. "To our knowledge, however, this case is the first instance in which the issue has been present in the context of a criminal prosecution." *Barber v. Superior Court*, 137 Cal. App. 3d 1006, —, 195 Cal. Rptr. 484, 488 (1983).

18. One writer notes that there are about 5,000 persistently vegetative patients currently cared for in the United States. See Rust, *Lifelines, Fine Lines*, *STUDENT LAW.*, Jan. 1984, at 12, 13. See also Gaylin, *Harvesting the Dead*, in *BIOETHICS* 517 (T. Shannon ed. 1981) (proposing that society should metabolically maintain donated cadavers for research, for surgical practice, and above all, as constant sources of vital fluids, tissues and organs). Gaylin believes that there would be a large number of salvageable, brain dead cadavers from "accidents (about 113,000 per year), suicides (around 24,000 per year), homicides (18,000), and cerebrovascular accidents (some 210,000 per year)." *Id.* at 525. However, it is difficult to determine how many of these victims are fit for this purpose because physicians practice "euthanasia on an ad hoc, casual, and perhaps irresponsible basis." *Id.* at 518.

This Article will address the propriety of the *Barber* decision and its ramifications. The purposes of the Article are twofold. First, it will be argued that, contrary to the *Barber* court's reasoning, intravenous feeding and hydration are not treatments but rather sustenance; therefore, they cannot be discontinued simply because a patient is incurably comatose. This position will be analyzed in Part II of this Article. The second, and major, purpose is to recommend methods for dealing with the problems inherently associated with the care of incurably comatose patients. An appraisal of these methods will be made in Part III of this Article.

II. THE CONSEQUENCES OF WITHDRAWING THE I.V.

The effect of the *Barber* decision was to establish legal precedent for the position that withholding nutrition and hydration from comatose patients is not murder. For a proper analysis of this position, the first consideration must be the pertinent legal history existing prior to the *Barber* decision. After a brief summation of the legal precedent, the case and its ramifications will be explored.

A. The Line of Authority

The debate over the justification for discontinuing life-support systems rests mainly in a diversity of axioms attributable to different ethical theories.¹⁹ This diversity is seen in the disparate statutes²⁰ and court decisions²¹ handed down across the nation. Each represents a philosophy of the issuing institution pertaining to the use and disuse of life-support equipment. While the rationales are conflicting, the end results always hinge on the courts' determination of whether it is better to maintain a comatose but metaboli-

19. The conflict is waged primarily between four prominent schools of philosophical thought. *Act utilitarianism* would view the withdrawal as acceptable if it would maximize the total good. On the other hand, *rule utilitarianism* focuses on the resulting societal insecurity that is fostered by the killing of innocent human beings and the moral decay and callousness that would result once any form of killing is allowed. *Natural law (or modern Thomism)* would turn to the "principle of double effect" to determine whether the morally good result prevails. *Kantian principles* would demand that one treat the patient as an end rather than a means to an end, the result of which is to challenge the actor to prove the act's moral validity by demonstrating that it should become a universal law. For a thorough analysis of these ideological clashes and their consequences in medical decisionmaking, see D. WALTON, *ETHICS OF WITHDRAWAL OF LIFE-SUPPORT SYSTEMS* 1-29 (1983).

20. Some states adhere to common law notions of death, while others have adopted statutes similar to the Uniform Determination of Death Act. *Id.* at 76-79. For a discussion of the common law definition of death, see *infra* notes 91 & 181. For a discussion of the Uniform Determination of Death Act, see *infra* text accompanying notes 187-91.

21. See *infra* notes 60-69 and accompanying text.

cally alive patient, or to succumb to the concept of "death with dignity"?²²

In civil cases, the courts have balanced both the constitutional and common law rights of the patient and the state. The constitutional footings concerning the care of dying or immedicable patients were firmly set in *In re Quinlan* on March 31, 1976.²³ In this case, an unconscious Karen Ann Quinlan arrived by ambulance at Newton Memorial Hospital after her breathing had stopped.²⁴ She was placed on a respirator and later diagnosed to be in a "chronic persistent vegetative state."²⁵ Neurologists determined that Ms. Quinlan was not brain dead,²⁶ but that she would never regain sapient cognizance.²⁷ When the medical staff refused to honor the family's request that the respirator be removed, Karen's father brought suit to become her appointed guardian. He sought this status under the assumption that it would enable him to order the physicians to withdraw Karen's respirator.²⁸

In reversing the lower court's decision, the New Jersey Supreme Court held that the constitutional right to privacy²⁹ incor-

22. But see Jackson & Youngner, *Patient Autonomy and "Death With Dignity": Some Clinical Caveats*, 20 JURIMETRICS J. 348 (1980) (concerning the practical difficulty of defining "death with dignity" on a case by case basis).

23. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976).

24. *Id.* at 23, 355 A.2d at 653-54.

25. A chronic persistent vegetative state was defined by expert witness Dr. Fred Plum as the condition of a "subject who remains with the capacity to maintain the vegetative parts of neurological function but who . . . no longer has any cognitive function." *Id.* at 24, 355 A.2d at 654. Dr. Plum distinguished cognitive or sapient functions from vegetative functions of the brain, and indicated their relevance to the concept of "brain death":

We have an internal vegetative regulation which controls body temperature, which controls breathing, which controls to a considerable degree blood pressure, which controls to some degree heart rate, which controls chewing, swallowing and which controls sleeping and waking. We have a more highly developed brain which is uniquely human which controls our relation to the outside world, our capacity to talk, to see, to feel, to sing, to think. Brain death necessarily must mean the death of both of these functions of the brain, vegetative and the sapient. Therefore, the presence of any function which is regulated or governed or controlled by the deeper parts of the brain which in laymen's terms might be considered purely vegetative would mean that the brain is not biologically dead.

Id. at 24, 355 A.2d at 654-55.

26. *Id.* See *infra* note 75.

27. *In re Quinlan*, 70 N.J. 10, 26, 355 A.2d 647, 655 (1976).

28. *Id.* at 18, 355 A.2d at 651.

29. The right of privacy emanates from the penumbra of guarantees expressed by the Bill of Rights and implied in the first, fourth, ninth and fourteenth amendments. *Griswold v. Connecticut*, 381 U.S. 479 (1965). From this unspecified zone, courts have reasoned that the individual has a constitutional right to refuse medical treatment. See, e.g., *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1980); *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980);

porated a right to choose or decline medical treatment that invariably leads to a vegetative patient's right to die.³⁰ A two-step determination thus ensues: first, since a patient may choose to die under these situations, and "no external compelling interest of the State could compel [the patient] to endure the unendurable,"³¹ a quality of life judgment must be made;³² second, a substituted judgment test³³ then determines whether that particular incompetent patient would elect to continue at that level of existence.³⁴ The New Jersey Supreme Court believed that Ms. Quinlan would have opted against further treatment if she was competent to do so.³⁵ This determination arguably created a presumption that patients in a vegetative state would prefer non-treatment.³⁶ Karen was moved to Morris View Nursing Home.³⁷ The respirator was disconnected but Karen continued to breathe on her own and sur-

Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Conroy*, 190 N.J. Super. 453, 464 A.2d 303 (1983); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 738 (1983); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983). For a discussion of the balancing of state and constitutional interests in treatment decisions, see generally Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus The Preservation of Life*, 26 *RUTGERS L. REV.* 228 (1973); Note, *Compulsory Medical Treatment and Constitutional Guarantees: A Conflict?*, 33 *U. PITT. L. REV.* 628 (1972).

30. *In re Quinlan*, 70 N.J. 10, 39, 355 A.2d 647, 663 (1976).

31. *Id.*

32. The quality of life concept assumes that a line can be drawn at a point where life is no longer worth living. D. CRANE, *THE SANCTITY OF SOCIAL LIFE: PHYSICIANS' TREATMENT OF CRITICALLY ILL PATIENTS* (1975). *But see* St. Martin, *Euthanasia: The Three-In-One Issue*, 27 *BAYLOR L. REV.* 62 (1975) (arguing that life is always worth living).

33. The test's designation—"substitute judgment"—has a complex and legitimate ring to it. The irony is that allowing one to refuse treatment for another, under the presumption that the patient would not want to continue to exist in his present condition, is inconsistent with society's sanctions against suicide. Why should an incompetent person's imputed wish to die be honored, while the same desire of a completely cognizant person would be denied? For example, Judge Hews of the California Superior Court of Riverside County refused to grant a quadriplegic cerebral palsy victim's request not to be fed. *Death*, 70 A.B.A. J., Feb. 1984, at 29. Elizabeth Bouvia was denied the restraining order to prevent the hospital from force-feeding her, because she was mentally competent. *Id.* The rationale was simple: "We honestly hope this young woman will realize there is hope in life." *Id.* See also P. RAMSEY, *ETHICS AT THE EDGES OF LIFE* 287-99, 331-32 (1979) (discussing the flaws and dangers in the substituted judgment test); Comment, *Baby Doe Decisions: Modern Society's Sins of Omission*, 63 *NEB. L. REV.* 888, 923-26 (1984).

34. *In re Quinlan*, 70 N.J. 10, 44, 355 A.2d 647, 664 (1976).

35. *Id.* at 39, 355 A.2d at 663.

36. See Note, *The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State*, 51 *N.Y.U. L. REV.* 285 (1976).

37. P. RAMSEY, *supra* note 33, at 298.

vives today with the aid of intravenous feeding.³⁸

In re Storar exhibits the common law side of the legal spectrum.³⁹ The *Storar* decision consolidated the cases of Brother Fox, an 83-year-old vegetative patient whose life was dependent upon a respirator, and John Storar, an extremely retarded, terminally-ill patient in need of blood transfusions to survive.⁴⁰ The New York Court of Appeals found that, at a time when Brother Fox was competent, he had expressed his desire to not be submitted to life-prolonging procedures when there would be no chance of recovery.⁴¹ The court held that Brother Fox had refused to consent to the current use of the respirator and authorized disconnection.⁴² The decision was based upon the common law right to one's own bodily integrity.⁴³ From this foundation arises the doctrine of informed consent,⁴⁴ mandating that physicians must disclose the risks and benefits of the proposed treatment to the patient in order for an educated choice to be made. Once the patient reaches a decision, it is the physician's duty to respect the patient's wishes; in fact, the doctor is liable for battery if he treats the patient without the required consent.⁴⁵

Neither the common law nor the constitutional right to refuse treatment is absolute. If any of four state interests outweigh the individual's right to refuse treatment, that state may have the treatment performed.⁴⁶ These four interests are: (1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession.⁴⁷ The most important of these interests is the preservation of life. Under its guise, non-consenting patients have been required to receive life-saving treatment.⁴⁸ Only the quality of life argument has been successful in

38. Rust, *supra* note 18, at 16.

39. *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

40. *Id.* at 370, 420 N.E.2d at 66, 438 N.Y.S.2d at 268.

41. *Id.* at 379-80, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.

42. *Id.* at 384, 420 N.E.2d at 74, 438 N.Y.S.2d at 276.

43. *Id.* at 377, 420 N.E.2d at 70, 438 N.Y.S.2d at 272.

44. *Id.*

45. See W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 18, at 104 (4th ed. 1971).

46. See *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1980); *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976); *In re Conroy*, 190 N.J. Super. 453, 464 A.2d 303 (1983); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983).

47. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 735, 370 N.E.2d 417, 425 (1977).

48. See *In re President and Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971).

outweighing this interest.⁴⁹ However, in the case of the comatose patient, the doctrine of *parens patriae*⁵⁰ intensifies the state's interest since the patient is incompetent.⁵¹ This doctrine allows the state to intervene and determine whether the incompetent person's best interests are being met.

The holdings have laid down multiple guidelines for properly resolving the dilemma. It has been found that the decision to withdraw life-sustaining treatment is to be made by the doctor and patient alone.⁵² This reasoning supports the use of a Living Will,⁵³

49. See Note, *In re Quinlan: One Court's Answer to the Problem of Death With Dignity*, 34 WASH. & LEE L. REV. 285 (1977).

50. "*Parens patriae*" is defined literally as "parent of the country." BLACK'S LAW DICTIONARY 1003 (5th ed. 1979).

51. "Traditionally, the term was used to refer to the King's power as guardian of persons under legal disabilities to act for themselves . . . In the United States, the 'royal prerogative' and the 'parens patriae' function of the King passed to the States." *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972).

52. *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

53. The Living Will has been explained as follows:

The Living Will is a document through which a person, while still competent, directs that certain measures, usually so-called "heroic medical measures," not be used to prolong life and suffering should the person become terminally ill with no reasonable expectation of recovery, and be unable to personally make treatment decisions. Its purposes are: 1) to assure patient autonomy in regard to treatment during terminal illness, after the patient has become comatose or incompetent; and 2) to offer a measure of protection against liability to physicians, health care professionals and institutions by providing documentation that the patient's consent to the withholding or withdrawing of available life-prolonging technology, although given in advance, was informed and understanding.

Concern for Dying, A Legal Guide to the Living Will (Aug. 1983). The following is a recommended example of the Living Will:

TO MY FAMILY, MY PHYSICIAN, MY LAWYER AND
AND ALL OTHERS WHOM IT MAY CONCERN

Death is as much a reality as birth, growth, maturity and old age—it is one certainty of life. If the time comes when I can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes and directions, while I am still of sound mind.

If at such time the situation should arise in which there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die and not be kept alive by medications, artificial means or "heroic measures." I do, however, ask that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life.

This statement is made after careful consideration and is in accordance with my strong convictions and beliefs. I want the wishes and directions here expressed carried out to the extent permitted by law. Insofar as they are not legally enforceable, I hope that those to whom this Will is addressed will regard themselves as morally bound by these provisions.

Signed _____

that has been advocated, and in some states adopted, as a panacea in the realm of life-sustaining treatment and the incompetent patient.⁵⁴ In other jurisdictions, the existence of a Living Will has been held to be of some evidentiary value but not necessarily sufficient to control the outcome of the decision.⁵⁵ Regardless of holdings limiting court review,⁵⁶ many courts have found that the decision of whether a patient must undergo treatment should be left to the judiciary.⁵⁷ Lastly, the use of ethics committees has been both judicially praised⁵⁸ and condemned.⁵⁹

While the courts have presented numerous guidelines to aid in treatment versus non-treatment decisions, the guidelines cannot be used to withdraw intravenous tubes until it is determined whether nutrition and hydration are forms of treatment. *In re Conroy* addressed this issue prior to the *Barber* decision.⁶⁰ Immobilized by organic brain syndrome⁶¹ and numerous physical

Date _____

Witness _____

Witness _____

Copies of this request have been given _____

Concern for Dying, A Living Will (35th printing May, 1978).

54. See ARK. STAT. ANN. §§ 82-3801 to -3804 (Supp. 1979); CAL. HEALTH & SAFETY CODE §§ 7185-95 (West Supp. 1982); IDAHO CODE §§ 39-4501 to -4508 (Supp. 1982); KAN. STAT. ANN. §§ 65-28, 101-09 (Supp. 1980); NEV. REV. STAT. §§ 449.540-690 (1977); N.M. STAT. ANN. §§ 244-7-1 to -11 (1978); N.C. GEN. STAT. §§ 90-320 to -321 (Supp. 1979); OR. REV. STAT. §§ 97.050-090 (1981); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1982); WASH. REV. CODE ANN. §§ 701.122.010-.905 (Supp. 1981).
 55. See *John F. Kennedy Memorial Hosp. v. Blutworth*, 432 So. 2d 611 (Fla. Ct. App. 1983).
 56. See, e.g., *In re Quinlan*, 70 N.J. 10, 50, 355 A.2d 647, 665-66 (1976); *In re Colyer*, 99 Wash. 2d 114, —, 660 P.2d 738, 746 (1983).
 57. See, e.g., *Severns v. Wilmington Medical Center*, 421 A.2d 1334, 1350 (Del. 1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 *passim* (1977).
 58. See *In re Quinlan*, 70 N.J. 10, 49-50, 355 A.2d 647, 668-69 (1976).
 59. See *In re Colyer*, 99 Wash. 2d 114, —, 660 P.2d 738, 749 (1983) (finding that ethics committees do not serve their desired function—a function best served by a prognosis board).
 60. *In re Conroy*, 190 N.J. Super. 453, 464 A.2d 303 (1983), was decided on July 8th. *Barber* was decided three months later, on Oct. 12th. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).
 61. "Organic brain syndrome" is defined as "[a] syndrome resulting from diffuse or local impairment of brain tissue function, manifested by alteration of orientation, memory, comprehension, and judgment" It is not the same as senile dementia, which is "mental deterioration caused by atrophy of the brain due to aging."
- In re Conroy*, 190 N.J. Super. 453, 456 n.1, 464 A.2d 303, 304 n.1 (1983) (quoting DOX, MELLONI & EISNER, ILLUSTRATED MEDICAL DICTIONARY 347 (1979)).

disabilities,⁶² 84-year-old Claire C. Conroy was conscious, but described as "severely demented." She received nutrition and hydration through a nasogastric tube.⁶³ The court held that the intervenous fluids were not treatment that could be halted under a right to privacy argument or on any other basis.⁶⁴ Dehydrating and starving this patient to death would have been viewed as homicide.⁶⁵

While the Superior Court of New Jersey declined to rule on whether nutrition could ever be withheld from an incurable patient, the decision overturned the lower court and held that a patient must be provided with nutrition unless he is comatose, brain dead, or vegetative, and death is irreversibly imminent.⁶⁶ The superior court opined that the lower court's ruling allowing the nasogastric tube's disconnection was legally and ethically unacceptable.⁶⁷

It is clear that the physician's primary obligation is *primum non nocere*: First do no harm. The Hippocratic Oath provides in part: "*I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone.*" As an extension of these maxims, medical ethicists have long distinguished between killing and letting die. Hyland and Baime frame the distinction as one between euthanasia ("the deliberate easing into death of a patient suffering from a painful and fatal disease") and antidythanasia ("the failure to take positive action to prolong the life of an incurable patient"). Hyland & Baime, *In re Quinlan: A Synthesis of Law and Medical Technology*, 8 RUT.-CAM.L.J. 37, 52 (1976). While the latter has gained acceptance in the medical community, the former always has been considered unethical.⁶⁸

The *Conroy* court concluded that the lower court had authorized euthanasia by allowing nourishment to be withdrawn, and refused to extend the *Quinlan* holding to allow sustenance to be withheld

62. She had diabetes, causing necrotic ulcers to develop on her left foot. Although Miss Conroy followed movements with her eyes, she did not respond to verbal stimuli. Afflicted with gangrene and left in a semi-fetal position by the contraction of her lower leg muscles, she was dependent upon nursing care for survival. *Id.* at 457-58, 464 A.2d at 304-05.

63. The tube is described as "a simple flexible plastic tube that is run through the patient's nose into the stomach and through which liquid nutrients are passed." *Id.* Mr. Herbert's nasogastric tube was removed by the defendant, Dr. Nejd. *People v. Barber*, No. A 025 586, at 3 (Cal. L.A. County Super. Ct. 1983).

64. *In re Conroy*, 190 N.J. Super. 453, 469-70, 464 A.2d 303, 312 (1983). The court reasoned, "[n]ourishment does not itself cure disease. Neither is it an artificial life-sustaining device. Rather it is a basic necessity of life whose withdrawal causes death and whose provision permits life to continue until the patient dies of his illness or injury." *Id.*

65. *Id.* at 461, 464 A.2d at 306-07.

66. *Id.* at 469, 464 A.2d at 312.

67. *Id.* at 473-74, 464 A.2d at 314.

68. *Id.*

from the incompetent person in this case.⁶⁹ The differences between this holding and the *Barber* decision must now be examined.

B. Barber v. Superior Court of Los Angeles County

Mr. Clarence Herbert was admitted to Kaiser Hospital for the routine removal of a colostomy bag and surgical closure of an ileostomy⁷⁰ on August 24, 1981. Two days later, Doctor Robert Nejd, along with his attending internist, Doctor Neil Barber, successfully performed surgery to close the patient's ileostomy.⁷¹ The procedure was short and uneventful. Mr. Herbert was revived by the anesthetist and moved to the recovery room. Later, in the recovery room, a nurse discovered the patient in a cyanotic condition.⁷² Attending nurses and physicians promptly resuscitated Mr. Herbert and placed him on life-support systems. The anoxic⁷³ insult left the patient comatose: no response to stimuli was reported.⁷⁴ After being apprised of the situation, Mrs. Herbert expressed that her husband would not wish to remain a "vegetable."

On August 27, Doctors Nejd, Magnusson, Barber, and Freedman reached the prognosis that, while the patient had not suffered brain death,⁷⁵ Mr. Herbert would permanently remain in a "vegetative" state.⁷⁶ Dr. Freedman finished his examination by taking an EEG⁷⁷ of Mr. Herbert. The following morning, after evaluating the EEG results, Dr. Freedman concluded his diagnosis and recom-

69. *Id.* at 476, 464 A.2d at 315.

70. Ileostomy is defined as the "surgical creation of an opening into the ileum [part of the small intestine], usually by establishing an ileal stoma on the abdominal wall." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 650 (26th ed. 1981) [hereinafter cited as DORLAND'S].

71. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 486 (1983).

72. "Cyanosis" is defined as "a bluish discoloration, applied especially to such discoloration of skin and mucous membranes due to excessive concentration of reduced hemoglobin in the blood." DORLAND'S, *supra* note 70, at 333.

73. Anoxia results from an inadequate "oxygen supply to tissue despite adequate perfusion of the tissue by blood; the term is often used interchangeably with *hypoxia*, to indicate a reduced oxygen supply." *Id.* at 85.

74. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 486 (1983).

75. The definition of "brain death" is generally based upon the criteria established by the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 J. A.M.A. 337 (1968). The criteria consist of no responsivity, no movements or breathing, no reflexes, and, for confirmatory reasons, a flat electroencephalogram (hereinafter referred to as an EEG). *Id.* at 337-38.

76. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 486 (1983).

77. An EEG is a charting of one's brainwaves. DORLAND'S, *supra* note 70, at 426.

mended "non-heroic supportive care."⁷⁸ The doctors informed the patient's family that Mr. Herbert's condition was inmedicable, with little or no chance of recovery. Mr. Herbert's family issued the following: "We the immediate family of Clarence LeRoy Herbert on this day of August 29th 1981 would like all machines taken off [sic] that are sustaining life. We release all liability to Hosp. Dr. & staff. The family."⁷⁹ Dr. Barber removed the respirator and had the moisture to Mr. Herbert's endotracheal tube halted. "The likely result of this order, which was only changed two and a half hours later at the insistence of a concerned nurse, was death by 'mucus plug.'⁸⁰ When Mr. Herbert's active brain stem⁸¹ continued to stimulate his bodily functions, the family urged the doctors to remove the intravenous tubes (hereinafter referred to as I.V.'s).⁸² Their desires were met, and after six days of dehydration, resulting in the loss of six liters of body fluid,⁸³ Mr. Herbert was pronounced dead. Dr. Nejd and Dr. Barber were charged with murder for causing their patient's "life boat death."⁸⁴

1. *Holding of the Court*

In a decision which the prosecution decided not to appeal,⁸⁵ the California Court of Appeals held that the appellants' murder charges were properly dismissed after the original court's preliminary hearing.⁸⁶ The appellate court commented that the death was

78. Defendant's Brief, *supra* note 1, at 5.

79. Defendant's Brief, *supra* note 1, at 6.

80. Prosecution's Brief, *supra* note 3, at 8. For an explanation of the prosecutor's use of this term, see *supra* note 3.

81. The brainstem is "the stemlike portion of the brain connecting the cerebral hemispheres with the spinal cord and comprising [the sensory and motor terminals and the nucleus of the cranial nerves]." DORLAND'S, *supra* note 70, at 188. For further information, see *supra* note 25.

82. See *supra* note 4.

83. Such a loss was a "condition incompatible with life." Prosecution's Brief, *supra* note 3, at 9.

84. *Id.* "Prison camp death" was another metaphor used by the prosecutor to describe Mr. Herbert's fate. *Id.* The visual images of hopelessly stranding a person at sea or locking him in a cell without nutrition and water are emotionally repulsive. The victim is visualized as attempting to escape, to survive, and, in the end, accepting and reflecting upon his feelings of hopelessness and despair. Are these same feelings attributable to comatose patients? The metaphors are not entirely accurate. In the case of the life boat or prison camp, society's repulsion is centered partly upon the victim's emotional misery. Nevertheless, even though the disgust is not as acute, the imagery of a comatose person dying of dehydration in a life boat or prison camp is still emotionally disturbing—particularly when there is one nearby who could easily quench that person's thirst.

85. Rust, *supra* note 18, at 14.

86. Barber v. Superior Court, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 494 (1983).

a homicide resulting from an omission⁸⁷—the omission being the withdrawal of the I.V.'s. Since one is not liable for an omission in the absence of a duty,⁸⁸ the physicians could not be tried for murder: they were not obligated to continue nourishment and hydration, since the I.V.'s were noncurative treatment.⁸⁹

2. *Analysis of the Decision*

The threshold question in *Barber* was whether the patient should be considered alive, since the physicians could not have been charged with the murder of a patient who was already dead.⁹⁰ According to the historical definition, death is established with the end of all pulmonary and respiratory operations.⁹¹ In contrast, this modern death statute of California termed death as the "total and irreversible cessation of brain function."⁹² The court concluded that Mr. Herbert, according to the historical and statutory criteria, was not dead at the time the I.V.'s were withdrawn.⁹³ Many commentators have agreed with the court's finding,⁹⁴ while others

87. *Id.* at ___, 195 Cal. Rptr. at 487-88.

88. *Id.* at ___, 195 Cal. Rptr. at 490.

89. *Id.* at ___, 195 Cal. Rptr. at 491-92.

90. Homicide requires the victim to be a living human being at the time of the crime. "Shooting a dead body is not homicide, although it may be another crime." W. LAFAYE & A. SCOTT, HANDBOOK ON CRIMINAL LAW § 67, at 530 (1972).

91. *In re Quinlan*, 70 N.J. 10, 32, 355 A.2d 647, 656 (1976) (citing *A Definition of Irreversible Coma*, *supra* note 75, at 339).

92. CAL. HEALTH & SAFETY CODE § 7180 (Deering 1975) provides:

A person shall be pronounced dead if it is determined by a physician that the person has suffered a total and irreversible cessation of brain function. There shall be independent confirmation of the death by another physician. Nothing in this chapter shall prohibit a physician from using other usual and customary procedures for determining death as the exclusive basis for pronouncing a person dead.

Id. After Mr. Herbert's death, the statute was amended to read:

(a) An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

(b) This article shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this article among states enacting it.

(c) This article may be cited as the Uniform Determination of Death Act.

CAL. HEALTH & SAFETY CODE § 7180 (Deering Supp. 1984). Due to the nonfunctioning brain stem requirement, the amended statute would not have altered the labeling of Mr. Herbert as a "living" human being.

93. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 488 (1983).

94. See D. WALTON, *supra* note 19, at 103-05; Annas, *Defining Death: There Ought to be a Law*, 13 HASTINGS CENTER REP., Feb. 1983, at 20; Bernat, Culver, &

would argue that the patient was not a "living person"⁹⁵ with a right to burden society with his metabolic maintenance.⁹⁶

Of course, the term homicide simply connotes the death of an individual "*at the hands of another*."⁹⁷ The court accepted the patient's death as a homicide and focused its opinion upon whether the defendants had committed murder—"the unlawful killing of a human being with malice aforethought."⁹⁸ A homicide is generally

Gert, *Defining Death in Theory and Practice*, 12 HASTINGS CENTER REP., Feb. 1982, at 5. See also PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DEFINING DEATH: MEDICAL, LEGAL, AND ETHICAL ISSUES IN THE DETERMINATION OF DEATH* (1981).

95. For consideration of one's moral status as a "person" and the conditions which constitute the presence of "personhood," see D. CALLAHAN, *ABORTION: LAW, CHOICE AND MORALITY* (1970); Engelhardt, "*The Ontology of Abortion*," 84 ETHICS, Apr. 1974, at 217; Tooley, *A Defense of Abortion and Infanticide*, in *THE PROBLEM OF ABORTION* 51 (J. Feinberg ed. 1973); Warren, "*On the Moral and Legal Status of Abortion*," in *TODAY'S MODERN PROBLEMS* 120 (R. Wasserstrom ed. 1975). And for argument against the use of "personhood" in ethical decisionmaking, see Atkinson, *Persons in the Whole Sense*, 22 AM. J. JURIS. 86 (1977).

96. Dr. Irvine Page has suggested that the nation's entire gross national product could someday be consumed by maintaining all life for as long as it could be maintained, and that "the money spent to maintain unconscious and hopelessly damaged persons could be used to restore those who are salvageable." Robitscher, *The Right to Die*, 2 HASTINGS CENTER REP., Feb. 1976, at 11, 14. The *Barber* court stated repeatedly that the issues involved were best decided by the legislature; yet, ironically, it based its holding on the inability of California law to deal with the problem of the vegetative patient. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 489-90 (1983). It may be argued that a proper reading of the California Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185-95 (Deering Supp. 1984), which allows the use of Living Wills with instructions to withhold life-sustaining treatment, *id.* at § 7188, concerns itself with just such a case. See, e.g., Prosecution's Brief, *supra* note 3, at 6, 14. In response to such an argument, the court, in *Barber*, suggested that "[i]n adopting the Natural Death Act, the legislature has gone part-way, but only part-way, in dealing with this troublesome issue." *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 489 (1983) (citation omitted).

However, the court muddled the waters when it stated that the legislature's guidance is inadequate in this situation, yet, in another breath, announced that the proper standard to be applied is that standard set by the legislature. This legislature had previously created the California Natural Death Act. Since the court has articulated that the legislature is the "body which must address the moral, social, ethical, medical and legal issues raised by cases such as this one at bench," *id.*, the court should interpret the passage of the Natural Death Act as a statement of legislative policy that withdrawal of life-support systems is acceptable only under the law's specific criteria.

97. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 487 (1983) (emphasis added).

98. BLACK'S LAW DICTIONARY 918 (5th ed. 1979).

unlawful unless it falls within the statutory exceptions of justifiable or excusable conduct.⁹⁹ Neither concept was held to be applicable under California law.¹⁰⁰ Hence, the court had to search elsewhere in its quest to find that the defendants had acted lawfully.

The court used the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research to support its position that physicians should not be subject to criminal prosecutions in like situations.¹⁰¹ Commentators have expressed an opposite view¹⁰²—a view which the *Barber* court im-

99. See generally W. LAFAVE & A. SCOTT, *supra* note 90, §§ 47-57 (justification or excuse of a crime).

100. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 488. The noted statutes are presented below:

Excusable Homicide. Homicide is excusable in the following cases:

1. When committed by accident and misfortune, in lawfully correcting a child or servant, or in doing any other lawful act by lawful means with usual and ordinary caution, and without any unlawful intent.
2. When committed by accident and misfortune, in the heat of passion, upon any sudden and sufficient provocation, or upon a sudden combat, when no undue advantage is taken, nor any dangerous weapon used, and when the killing is not done in a cruel or unusual manner.

CAL. PENAL CODE § 195 (Deering 1975).

Homicide is also justifiable when committed by any person in any of the following cases:

1. When resisting any attempt to murder any person, or to commit a felony, or to do some great bodily injury upon any person; or,
2. When committed in defense of habitation, property, or person, against one who manifestly intends or endeavors, by violence or surprise, to commit a felony, or against one who manifestly intends and endeavors, in a violent, riotous or tumultuous manner, to enter the habitation of another for the purpose of offering violence to any person therein; or,
3. When committed in the lawful defense of such person, or of a wife or husband, parent, child, master, mistress, or servant of such person, when there is reasonable ground to apprehend a design to commit a felony or to do some great bodily injury, and imminent danger of such design being accomplished; but such person, or the person in whose behalf the defense was made, if he was the assailant or engaged in mutual combat, must really and in good faith have endeavored to decline any further struggle before the homicide was committed; or,
4. When necessarily committed in attempting, by lawful ways and means, to apprehend any person for any felony committed, or in lawfully suppressing any riot, or in lawfully keeping and preserving the peace.

CAL. PENAL CODE § 197 (Deering 1975).

101. *Barber v. Superior Court*, 137 Cal. App. 3d, 1006, ___, 195 Cal. Rptr. 484, 488 (1983).

102. See R. VEATCH, *DEATH, DYING AND THE BIOLOGICAL REVOLUTION* 1, 61 (1976).

plicity found to have some pertinent weight. The prosecutor accused the defendants of attempting to cover-up, or mitigate, malpractice damages.¹⁰³ Even though the court failed to deal expressly with this accusation, it did uphold the superior court's view that malice could be presumed if Mr. Herbert was unlawfully and intentionally killed.¹⁰⁴

While motive is not traditionally an express element of murder in this country,¹⁰⁵ it is difficult to separate the concepts of motive and malice aforethought.¹⁰⁶ Malice can be inferred "when no considerable provocation appears, or when the circumstances attending the killing show an abandoned and malignant heart."¹⁰⁷ This clearly indicates that the physicians would have been criminally liable had they acted with the underlying motive of concealing or minimizing damages attributable to medical malpractice.¹⁰⁸ It is not difficult to imagine a case where an unscrupulous physician would attempt to reduce damages arising from his own malpractice. This scenario could be achieved through advising withdrawal of treatment to the patient's guardian when the prognosis is not actually hopeless. Due to the municipal court's findings of fact,¹⁰⁹ the opinion did not address the possible presence of unlawfulness through the defendant's motives.

The California Court of Appeals found that the physician's conduct did not fall under the state's murder statute by characterizing that conduct as an omission rather than an action.¹¹⁰ One is not criminally liable for an omission to act unless he owes a particular duty to the individual in peril;¹¹¹ however, the disconnection of the patient's I.V. was not an omission. The I.V. is a technological means of providing sustenance. The use of this technology requires action, and the *disconnection* of such technology requires

103. Prosecution's Brief, *supra* note 3, at 13.

104. Barber v. Superior Court, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 487 (1983).

105. W. LAFAVE & A. SCOTT, *supra* note 90, § 29, at 204-08.

106. "[T]he lack of precision in defining malice often makes it difficult to disentangle motive from a determination of what constitutes malice." Barber v. Superior Court, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 487 (1983). See W. LAFAVE & A. SCOTT, *supra* note 90, at 29; G. WILLIAMS, CRIMINAL LAW § 21, at 48-50 (2d ed. 1961).

107. BLACK'S LAW DICTIONARY 919 (5th ed. 1979).

108. This creates a precarious situation since it is often difficult to determine where the fine line of medical malpractice begins.

109. "Although the actions of the attending physicians, Barber and Nejd, may be considered by some to have been precipitous, there is no evidence in the record before this court that such precipitous action was taken in violation of standards of medical and ethical conduct." People v. Barber, No. A 025 586, at 10 (L.A. Mun. Ct. 1983).

110. Barber v. Superior Court, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 487-90.

111. W. LAFAVE & A. SCOTT, *supra* note 90, § 27, at 190-91.

an opposite action. Therefore, it could be argued that the withdrawal of the I.V. was not an omission but an action.¹¹²

Nevertheless, the court utilized its omission standard to hold that the doctors had no professional duty to provide sustenance to their vegetative patient. The I.V. was treatment since "[m]edical procedures to provide nutrition and hydration are more similar to other medical procedures than to typical human ways of providing nutrition and hydration."¹¹³ This focus on the means of providing sustenance does not serve to justify the unacceptable end—the eventual dehydration and starvation of a *living* being. The court cited the President's Commission to reason that the distinction between a respirator and an I.V. is based on emotion rather than reason.¹¹⁴ This position is unacceptable. The *In re Conroy* holding (that nourishment is not treatment) is clearly preferable.¹¹⁵ The foundation of this position was best expressed by Daniel Callahan:¹¹⁶

The feeding of the hungry, whether because they are poor or because they are physically unable to feed themselves, is most fundamental of all human relationships. It is the perfect symbol of the fact that human life is inescapably social and communal. We cannot live at all unless others are prepared to give us food and water when we need them. If the duty of parents toward infants provides a perfect example of inescapable moral obligation, the giving of nourishment is its first and most basic manifestation. It is a most dangerous business to tamper with, or adulterate, so enduring and central a moral emotion, one in which the repugnance against starving people to death could be, on occasion, greater than that which a more straitened rationality would call for.¹¹⁷

Ignoring the holding in *Conroy*, the *Barber* court further held that physicians are not required to continue ineffective treatment, and, since California recognizes a competent adult's right to refuse

112. See Rachels, *Active and Passive Euthanasia*, in *SOCIAL ETHICS: MORALITY AND SOCIAL POLICY* 62-66 (T. Mappes & J. Zembaty eds. 1977).

113. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 490 (1983).

114. "[T]he people who love and care about the patient should have a voice in decisions. Certain options that are morally, medically, and legally valid might be quite unacceptable to them." PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT* 192 (1983) [hereinafter cited as *PRESIDENT'S COMMISSION*] (noting McCarthy, *Care of Persons in the Final State of Terminal Illness or Irreversibly Comatose*, in *MORAL RESPONSIBILITY IN PROLONGING LIFE DECISIONS* 196 (D. McCarthy & A. Moraczewski eds. 1981), who argues that the distaste for withholding nourishment is psychologically, rather than morally, based).

115. See *supra* note 64 and accompanying text.

116. Callahan is director of The Hastings Center. See Callahan, *On Feeding the Dying*, 13 *HASTINGS CENTER REP.*, Oct. 1983, at 22.

117. *Id.*

treatment¹¹⁸ as expressed through the patient's family, the homicide was not unlawful. This reasoning is tenuous in light of the fact that the court held that a homicide was involved that was defined as a death "at the hands of another."¹¹⁹ If the withdrawal of nourishment and hydration was an omission, then whose hands caused the homicide? The surgeon's? The anesthetist's? The court further muddled its logic:

In examining this issue we must keep in mind that the life-sustaining technology involved in this case is not traditional treatment in that it is not being used to directly cure or even address the pathological condition. It merely sustains biological functions in order to gain time to permit other processes to address the pathology.¹²⁰

The court's holding that an I.V. is treatment is incorrect for other reasons, as well. Since treatment traditionally involves "all the steps taken to effect a cure of an injury or disease,"¹²¹ one may argue that the I.V. is not treatment because its purpose does not propose to remedy the ailment.¹²² An argument in support of the court's position would contend that *treatment* focuses upon the health of the patient as a whole, rather than curing a particular disorder. Perhaps the latter view is preferable; even so, the court is not justified in equating treatment with nutrition and hydration. Holding that nourishment is medical treatment dangerously stretches medicine's domain. Such a position gives little credit to the true purpose of the medical profession. If nutrition actually is medical treatment, justice would demand that the American Medical Association open its ranks to many highly deserving chefs and nutritionists across the nation. But this is not the case. Medicine's purpose is to prevent and cure disease, and to provide physical comfort to those in pain. The duties of the profession are terminated once the patient is beyond pain and recovery.

Lay persons rely greatly upon the physician to guide them in making sound medical decisions; consequently, the doctor's integrity is essential to the decisionmaking process. He virtually controls the patient's decision as to treatment through his prognosis and recommendations.¹²³ The ordinary versus extraordinary distinction, which has been applied by some courts¹²⁴ to determine

118. See *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

119. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 487 (1983).

120. *Id.* at ___, 195 Cal. Rptr. at 490-91.

121. BLACK'S LAW DICTIONARY 1346 (5th ed. 1979).

122. See D. WALTON, *supra* note 19, at 220; Rachels, *supra* note 112.

123. See R. VEATCH, *supra* note 102, at 59-61. For the physician's decision in the intensive care unit, see D. WALTON, *supra* note 19, at 175-202.

124. See *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1980); *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Quinlan*,

whether to discontinue life-support systems, was found to be inappropriate by the *Barber* court.¹²⁵ Instead, the opinion's guidance for the physician was to weigh the patient's benefit from the treatment against the burdens imposed.¹²⁶ The President's Commission was cited to support the proposition that even a minimally burdensome treatment—intravenous feeding, perhaps—is disproportionate when there is no reasonable expectation of improvement.¹²⁷ According to the *Barber* court, "this determination is essentially a medical one to be made at a time and on the basis of facts which will be unique to each case."¹²⁸ The decision to withdraw treatment is, therefore, properly completed when the patient or his proxy is informed by the treating physician and he or his proxy consent to the withdrawal.¹²⁹

In summation, the *Barber* court reached five conclusions concerning the issues in route to its decision. The first, and most problematic, was that a treating physician commits murder when he nefariously disconnects an I.V. in order to mask or mitigate malpractice damages. The court dismissed the malpractice issue out-of-hand and turned to the second issue of the case. The I.V. was then held to be treatment rather than sustenance. This second determination became the essential premise of the remaining conclusions. Thirdly, withdrawing the I.V. was not an affirmative act; instead, it was held to be an omission to provide treatment to a patient who properly refused it. Logically independent from the third conclusion is the court's fourth finding, that a physician is not obligated to continue treatment when the benefit of that treatment is less than the burden it creates. Lastly, the court concluded that the decision to withdraw treatment is a medical one to be made by the treating physician—who, of course, may be held criminally liable—with the informed consent of the patient or his proxy. As a result of these conclusions, the court in *Barber* dismissed the criminal charges against the defendants.

70 N.J. 10, 355 A.2d 647 (1976); *In re Conroy*, 190 N.J. Super. 453, 464 A.2d 303 (1983); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983).

125. "The use of these terms begs the question. A more rational approach involves the determination of whether the proposed treatment is proportionate or disproportionate in terms of the benefits to be gained versus the burdens caused." *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 491 (1983).

126. *Id.*

127. *Id.*

128. *Id.*

129. *Id.* at ___, 195 Cal. Rptr. at 493.

III. ALTERNATIVES, RECOMMENDATIONS, AND CONCLUSIONS

A. The Ideological Components of Medical Decisionmaking

Regarding the question of who should make the decision as to whether the I.V. will be withdrawn, a majority of recent cases involving similar situations look to the patient as the final decisionmaker.¹³⁰ Logically, it may be quite reasonable for a patient in a consumer society that emphasizes individual freedom to be allowed the right to shop about and discern which treatment is the best. While patient autonomy formed the basis of the courts' decisions, other significant parties are essential to the decisionmaking process. Hospital guidelines must be followed by those who care for the patient and, occasionally, the hospital must also offer a triage¹³¹ argument in favor of disconnection, especially in the case of a full Intensive Care Unit (ICU).¹³² The patient's family is also integral to the decisionmaking process, especially because the economic factor of providing nursing care to an incurably comatose person may greatly influence the decision. Physicians control the data available to the patient or the patient's proxy—information that is necessary for an informed choice to be made about the patient's cure.¹³³ However, the state is the most significant party in the decisionmaking process. Subject to constitutional scrutiny, the state's laws, prosecutors, and courts will invariably control the range and availability of options that may be chosen.

Several premises exist for making such decisions. Pope Pius XII offered the ordinary versus extraordinary distinction as a basis for determining the correct care for patients,¹³⁴ but the Pope neglected to define the two terms. Treating extraordinary and ordinary synonymously with unusualness and usualness would be inappropriate within the medical community, since it arbitrarily leaves the patient's life dependent upon which hospital he is in.¹³⁵ Courts,¹³⁶ committees,¹³⁷ and commentators¹³⁸ have reached a

130. See D. WALTON, *supra* note 19, at 216.

131. "Triage" is sorting and ranking patients according to need and salvageability. *Id.*

132. "If an ICU is full, and if a patient with very good chances of recovery with critical care is waiting for a bed in the ICU, then a patient with not-so-good chances may have to be sent to a medical ward. Evidently, this type of situation is not very frequent, but it does happen." *Id.* This argument has little merit in the I.V. withdrawal case since the patient can simply be moved to a nursing facility for nourishment and hygienic care.

133. See *supra* notes 43-45 and accompanying text.

134. Pius XII, *The Prolongation of Life*, 4 POPE SPEAKS 393-98 (1958).

135. R. VEATCH, *supra* note 102, at 105-15.

136. See *supra* note 46.

137. See PRESIDENT'S COMMISSION, *supra* note 114, at 82-89. The views of the

consensus that the extraordinary/ordinary distinction is, in effect, a balancing of interests. This line of reasoning suggests that extraordinary treatment is that which, in the patient's view, entails significantly greater burdens than benefits and is, therefore, undesirable and not obligatory. Ordinary treatment, on the other hand, is that which, in the patient's view, produces greater benefits than burdens and is, therefore, desirable and must be undertaken. The claim, then, that the treatment is extraordinary is more of an expression of the conclusion than a justification for it. Various methods of treatment, coupled with circumstances unique to each patient, result in medical confusion and poor precedent; therefore, the extraordinary/ordinary test is an unsatisfactory route to decisions. The *Barber* court correctly recognized this inadequacy.¹³⁹

The next suggested guideline is rooted in the acting/omitting distinction presented by the *Barber* court,¹⁴⁰ and is analogous to the active/passive distinction that has been applied in the euthanasia¹⁴¹ discussion.¹⁴² Active euthanasia has never been legally accepted in this country.¹⁴³ Nevertheless, the courts have traditionally been lenient towards those who have mercifully put an end to a physically-suffering loved one's life.¹⁴⁴ Active euthanasia is best viewed as an action intentionally taken to assure a merciful death, without relying on another extraneous force to perform the task.¹⁴⁵ Passive euthanasia is explained as a release to the forces of nature and from the compulsion to avoid them.¹⁴⁶ As noted before,¹⁴⁷ an omission generally does not result in criminal liability unless there is a corresponding duty. The *Barber* court's use of "omission" clearly reflects a concept of passive euthanasia that is

American Medical Association and Canadian Medical Association are quoted in D. WALTON, *supra* note 19, at 223.

138. See D. WALTON, *supra* note 19, at 224; Robitscher, *supra* note 96.

139. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 491 (1983).

140. See *supra* notes 110-21 and accompanying text.

141. Euthanasia, literally translated, means "easy death." WEBSTER'S, THIRD NEW INTERNATIONAL DICTIONARY 786 (3d ed. 1971).

142. See R. VEATCH, *supra* note 102, at 97-103; D. WALTON, *supra* note 19, at 233-38; Beauchamp, *A Reply to Rachels on Active and Passive Euthanasia*, in SOCIAL ETHICS: MORALITY AND SOCIAL POLICY 67 (T. Mappes & J. Zembaty eds. 1977); Dinello, *On Killing and Letting Die*, 31 ANALYSIS, Jan. 1971, at 83; Geddes, *On the Intrinsic Wrongness of Killing Innocent People*, 33 ANALYSIS, Jan. 1983, at 93; Rachels, *supra* note 112.

143. See *Should There Be A Legal Right to Euthanasia?*, in SOCIAL ETHICS: MORALITY AND SOCIAL POLICY 35-36 (T. Mappes & J. Zembaty eds. 1977).

144. See Colletter, *Death, Dying and the Law: A Prosecutorial View of the Quinlan Case*, 30 RUTGERS L. REV. 304, 310 (1977).

145. D. WALTON, *supra* note 19, at 235-36.

146. *Id.*

147. See *supra* note 88 and accompanying text.

in line with previous decisions.¹⁴⁸

The essence of this distinction in defining the medical role is to draw the sometimes subtle distinction between those situations in which the withholding of extraordinary measures may be viewed as allowing the disease to take its natural course and those in which the same actions may be deemed to have been the cause of death.¹⁴⁹

The notion that a disease should take its course lends no credibility to the withdrawal of I.V.'s. The patient does not die of the disease that immobilized him; rather, his death results from dehydration and starvation.

The active/passive characterization has been addressed by several commentators, and those advocating the distinction focus principally upon the respective responsibilities and motives of the decisionmakers¹⁵⁰—primarily the socio-psychological implications of being an actor rather than a non-actor.¹⁵¹ Commentators have attacked the dichotomy because the result, and the respective knowledge of the individuals involved, are in fact identical, regardless of whether the incident concerned an action or an omission.¹⁵² One argument is that the categorization is relevant for the reason that the active killing of a human being conflicts with the physician's role in society.¹⁵³ The merit of this assumption is doubtful, since neglecting to save a human life when one has the power to do so is also contrary to the duties of the physician.

Another proposition in favor of the active/passive test involves the belief that the long-range consequences would be different if doctors practiced active, rather than passive, euthanasia.¹⁵⁴ Once the physician commits active euthanasia he is stepping onto a slippery slope¹⁵⁵ which will start a downhill slide to moral depravity. By condoning this form of killing, a "wedge" has been inserted into the public's condemnation of killing. Society can no longer hold the line against a legal progression toward the slaughter of those who are considered a nuisance to it. The fear may be well-founded, but the wedge is just as likely to be driven by passive euthanasia. In fact, passive nontreatment is currently used to rid

148. See *supra* notes 29-36 and accompanying text.

149. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 738, 370 N.E.2d 417, 423 (1977).

150. See, e.g., D. WALTON, *supra* note 19, at 233-38; Beauchamp, *supra* note 142.

151. See, e.g., D. WALTON, *supra* note 19, at 233-38; Beauchamp, *supra* note 142.

152. See Dinello, *supra* note 142; Geddes, *supra* note 142; Rachels, *supra* note 112.

153. R. VEATCH, *supra* note 102, at 83.

154. *Id.* at 87-88.

155. Commonly called the "wedge" argument, it is illustrated by the theory that the holocaust in Nazi Germany was a direct result of that society's acceptance and use of active euthanasia. Alexander, *Medical Science Under Dictatorship*, 241 NEW ENG. J. MED. 39 (1949).

society of undesirable infants.¹⁵⁶ It is obvious upon reflection that the active/passive dichotomy's vague criteria, and its policy ramifications, render the *Barber* court's omission standard inadequate as legal precedent. The dichotomy lends little security to future patients, doctors, and medical staffs faced with this dilemma.

B. Systems to Assure that Proper Decisions Are Made

The available methods to organize and guide decisionmaking toward a result that is both legally and morally satisfying will now be considered. The first two methods to be discussed, those of physician-patient and judicial intervention, are clearly inadequate when dealing with the incurably comatose patient. Two alternatives, statutory guidance and ethics committees, will then be strongly recommended. In order to appreciate the advantages of the recommended systems, the more undesirable methods will be examined first.

1. Physician-Patient Intervention

The guidelines set by the *Barber* court place the decisionmaking power solely within the physician-patient relationship.¹⁵⁷ This position has clearly evolved from society's interest in protecting individual freedoms,¹⁵⁸ and from its recognition of the patient's right to make decisions regarding his treatment and the emotional stress and financial strain he is willing to undertake.¹⁵⁹ When the patient is incompetent, as was the case in *Barber*, it is usually held that the patient's family may make the informed choice for him.¹⁶⁰ Under such circumstances, the resulting decision is usually the product of conflicting views and opinions.¹⁶¹ The doctor, who, according to the *Barber* court labors under the fear of criminal liability,¹⁶² must make a recommendation that will weigh heavily in the decisionmaking process. Ultimately, however, the decision rests with the family members who are presumed to know the patient's

156. See *Indiana ex rel. Infant Doe v. Monroe* Cir. Ct., No. 482 5140 (Ind. Sup. Ct. Apr. 16, 1982), *cert. denied*, 104 S. Ct. 394 (1983) (upholding the right of a handicapped infant's parents to cause the baby's death by withholding corrective surgery and nourishment). See also Comment, *supra* note 33.

157. See *supra* notes 128-29 and accompanying text.

158. See Comment, *The Problem of Prolonged Death: Who Should Decide?*, 27 BAYLOR L. REV. 169 (1975).

159. *Id.* at 170.

160. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 487 (1983).

161. See D. WALTON, *supra* note 19, at 211-15.

162. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 487 (1983).

desires and are capable of looking after his best interests.¹⁶³

The physician-patient system of decisionmaking inherently contains too many policy problems to be acceptable. Through the common law and statutory tradition, the family is often given guardianship of the incompetent.¹⁶⁴ The virtue of this practice is darkened by the family's own interest in disconnecting the I.V.:

One need not go so far back in history as Cain and Abel to recognize that the interests of various family members are not always synonymous nor even harmonious. The newspaper is a daily reminder that murderers are often related to their victims. [T]his consideration . . . is a factor which must be taken into account.¹⁶⁵

Even though the possibility that a family member would exercise his decisionmaking power to murder his kin may be remote, personal grudges and greed can become motivating factors in the decisionmaking process.¹⁶⁶

The physician's function in the system is also subject to serious doubt. Before recommending that the I.V.'s be withdrawn, the physician must initially diagnose his patient and then come to the conclusion that the patient is irreversibly moribund. Once this conclusion has been reached, the physician must inform the guardian of his prognosis and its consequences, so that the guardian can make an informed decision. Of course, a strong statement against painful treatment is recommended.¹⁶⁷ In addition, it has been advocated that the physician should be allowed to override the family's wishes until there is no doubt over the possibility of recovery.¹⁶⁸

Because the physician must serve interests other than those of his patient, his role in the decisionmaking process is problematic. For example, triage may compel the doctor to urge the disconnection of one patient so that others who require the use of the same limited medical resources,¹⁶⁹ or who are in need of an organ donor, can be cared for.¹⁷⁰ The physician must also consider the well-

163. *Id.* at ___, 195 Cal. Rptr. at 493.

164. "Not infrequently, the committee of the person and of the estate was entrusted to one and the same person. In other cases the heir, if he chose, was appointed committee of the estate, and the next of kin committee of the person." *In re Rollins*, 65 A.2d 667, 680 (N.J. Mercer County Ct. 1949).

165. *John F. Kennedy Memorial Hosp. v. Bludworth*, 432 So. 2d 611, 618 (Fla. Dist. Ct. App. 1983) (holding that the use of a Living Will, *see supra* note 53, is not in itself outcome determinative, but has great evidentiary value in judicial proceedings concerning the withdrawal of respirators from comatose patients).

166. *See* Comment, *supra* note 158, at 172.

167. *See* D. WALTON, *supra* note 19, at 180-81.

168. *Id.* at 200-02.

169. *Id.* at 117.

170. *See* Judicial Council, *Ethical Guidelines for Organ Transplantation*, 205 J. A.M.A. 341 (1968) (issuing guidelines to physicians in organ donor situations,

being of the patient's family, which may result in a bias toward withdrawing the I.V.¹⁷¹ "Ultimately, [the physician] tries to represent all of these 'patients' within the ill-defined decisionmaking formula He will try to diagnose something he calls 'hopelessness.' In the face of 'hopelessness,' he may decide to disconnect."¹⁷²

Perhaps the most persuasive argument against allowing the physician such prominence in the decisionmaking system is that the doctor's competency is in medicine, not in determining matters of public policy with regard to criminal liability or quality of life.¹⁷³ In addition, since the physician must make a recommendation under the shadow of possible criminal liability, it does not seem plausible to thrust the responsibility of making these life and death decisions upon him simply because he is a member of the medical profession.

2. Judicial Intervention

Another alternative is to leave the decision to the judiciary. The courts would be welcome participants in as much as:

- 1) Society already looks to the courts as arbitrators of questions of fact, even those with great moral ramifications.
- 2) Protecting the rights of individuals is a prime directive in our courts. Specifically, American courts are well versed in the nuances of our constitutional standards of due process as it applies to the right to life.
- 3) The courts would provide a forum where [interested] groups could co-ordinate their input of information and concern.
- 4) The courts could provide the ultimate safeguard against those who might not have the patient's best interest at heart.
- 5) Finally, the courts could provide the focal point for society's participation in this most crucial decision. Through the courts, society could share in the legal and moral responsibility of this decision which bears so heavily on individuals.¹⁷⁴

Although the legal process might be streamlined to quickly attend to these matters, the myriad of new cases¹⁷⁵ would severely encumber an already overtaxed judicial system with matters which usually become moot before a decision is rendered.¹⁷⁶ Also, there are serious economic questions that must be dealt with before vesting the decisionmaking power in the courts. For example,

one of which is that the physician owes his primary duty to his patient and must protect the donor and recipient equally).

171. See Levine, *Disconnection: The Clinician's View*, 6 HASTINGS CENTER REP., Feb. 1976, at 11.

172. *Id.* at 12.

173. See Kennedy, *Switching Off Life Support Machines: The Legal Implications*, 1977 CRIM. L. REV. 443, 444.

174. Comment, *supra* note 158, at 172-73.

175. See *supra* note 18.

176. See *In re Quinlan* 70 N.J. 10, 49-50, 355 A.2d 647, 669 (1976).

who should be forced to pay the court and hospital costs that rapidly aggregate during these often lengthy judicial proceedings? Is it fair to force an already suffering family to accept the burden? Obviously not. However, given the selfish and callous nature of our society, it would be unrealistic to expect that the taxpayer would be willing to foot the bill for this astronomical expense.¹⁷⁷

3. Statutory Guidelines

Under the common law, death was defined as the irreversible loss of vital fluid flow and separation of the soul from the body.¹⁷⁸ These two views of death still prevail, albeit in a slightly more refined form. Regrettably, the camps of debate are split, each adopting only one hybrid portion of the preceding benchmark. In one camp there are those who define death as the disintegration of the organism,¹⁷⁹ in the other, those who maintain that loss of personhood¹⁸⁰ is the end of that person's life.¹⁸¹ Supporters of the ces-

177. Our society is not committed to preserving life at any cost. In its broadest sense, this rather unpleasant notion should be obvious. Wars are fought. The University of Mississippi is integrated. But what is more interesting to the study of accident law, though perhaps equally obvious, is that lives are used up when the *quid pro quo* is not some great moral principle but "convenience." Ventures are undertaken that, statistically at least, are certain to cost lives. Thus, we build a tunnel under Mont Blanc because it is essential to the Common Market and cuts down the traveling time from Rome to Paris, though we know that about a man per kilometer of tunnel will die. We take planes and cars rather than safer, slower means of travel. And perhaps most telling, we use relatively safe equipment rather than the safest imaginable because—and it is not a bad reason—the safest costs too much.

Of course, it is rarely known who is to die. Indeed, in the uncanny case of an individual—a known individual rather than a statistical unknown—in a position of life or death, we are apt to spend very much more to save him than in any conceivable money sense he is worth. And while I do not doubt this is as it should be, it seems odd that we should refuse to apply the same standards of "value beyond any price" when we deal with the same man's life as part of a statistic. But odd or not, it is the case.

Calabresi, *The Decision for Accidents: An Approach to Nonfault Allocation of Costs*, 78 HARV. L. REV. 713, 716 (1965). It seems quite obvious that society would treat the incurably comatose patient's life as a statistic in determining whether it should foot the patient's bill during judicial proceedings. Medical services and products have astonishingly high price tags. When society plays with these figures, the result is likely to favor the preservation of medical resources, not because of moral principles but primarily out of greed and convenience.

178. See R. VEATCH, *supra* note 102, at 29-31.

179. See Bernat, Culver, & Gert, *supra* note 94.

180. See *supra* note 95; Steinbock, *The Removal of Mr. Herbert's Feeding Tube*, 13 HASTINGS CENTER REP., Oct. 1983, at 13.

181. It might also be argued that the loss of personhood may not be equivalent to

sation-of-the-organism criterion assert that death is a biological term which must be applicable to all species of life.¹⁸² This premise does not necessarily put the two positions at odds: each species could be deemed to have lost its status as a living creature upon the privation of characteristics which are attributable to its biological cognomen. For example, an amoeba with a destroyed nucleus could be legally accepted as dead, since it lacked the qualities of a living amoeba. Physiologists' opinions notwithstanding, there is no logical reason for law to characterize a human's death by metabolic function alone. The law has consistently focused upon behavior and viability¹⁸³ to find justice, and there is no sufficient reason to abandon this tradition in determining death. Therefore, it is conceivable that the cerebrum is the legal focus of death, and a legislature that wished to accept this view of death could do so statutorily.

Several professional organizations¹⁸⁴ have suggested that the states adopt the Uniform Determination of Death Act (UDDA) definition of death as law:

An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.¹⁸⁵

The UDDA is similar to the California statute¹⁸⁶ that classified Mr. Herbert as being alive at the time his I.V.'s were withdrawn.¹⁸⁷ If a legislature wished to adopt the cerebral standard of defining death, it could amend the UDDA,¹⁸⁸ replacing the term "brain" with cerebrum and deleting the phrase: "including the brain stem." Accepted medical technology would remain to determine whether cerebral death occurred. New indicators of death would not only be allowable, but encouraged.¹⁸⁹ The statute could also be ex-

death, but the state no longer has a compelling interest in preserving the life, since the "person" is no longer viable. See Note, *supra* note 36, at 291-93.

182. See Bernat, Culver, & Gert, *supra* note 94.

183. See, e.g., *Roe v. Wade*, 410 U.S. 113, 163 (1973) (holding in part that the unborn fetus is not a person protected by the fourteenth amendment, and the state's interest in the potential life is not "compelling" until the fetus reaches viability).

184. The American Medical Association, the American Bar Association, the National Conference of Commissioners on Uniform State Laws, and the President's Commission, support the UDDA. See Annas, *supra* note 94, at 20.

185. *Id.* at 21.

186. See *supra* note 92.

187. *Barber v. Superior Court*, 137 Cal. App. 3d 1006, ___, 195 Cal. Rptr. 484, 488 (1983).

188. For another proposal of a cerebral death statute, see R. VEATCH, *supra* note 102, at 76.

189. Neocordical and appallic diagnosis may become more definite, or the use of

panded to avoid conflicts of interest¹⁹⁰ and to include procedures for appeal.¹⁹¹

Of course, the need for legislation is absent where society agrees with the medically accepted view.¹⁹² In such an atmosphere, the physician would not labor under the fear of civil and criminal liability. The fact remains, however, that statutory definitions of death have great utility in today's social environment. Not only is society unable to agree with one medically accepted view, but the medical profession itself is unable to subscribe to a single determination of death.¹⁹³ Through public input, the legislation would embody the public will,¹⁹⁴ dispel doubt,¹⁹⁵ and relieve medical practitioners of liability.¹⁹⁶ This is clearly the most appropriate method of addressing the issue of whether to withdraw the I.V. from incurably comatose patients. If society does demand that nourishment be disconnected from patients who have lost all cerebral functioning, it is preferable to view that individual as dead rather than alive. The only reason to continue to feed a cadaver is to later extract its donated fluids and organs.¹⁹⁷ On the other hand, starving a person who is categorized as living would be deemed barbaric. Once we legally sanction the starvation of one socially undesirable person, can we prevent the withholding of nourishment to the severely retarded or handicapped?¹⁹⁸

Future medical decisions must be made in the void left by legislative inertia. This Article next discusses, and advocates, the use of ethics committees to protect the individuals involved in these decisions while the legislators redefine death. In fact, society may find that incurably comatose patients should never be denied food and water. Whichever route the legislators decide to follow, the result—from the body which has traditionally exercised the power

angiographs may be commonly adopted. *See* D. WALTON, *supra* note 19, at 70-72, 100-03.

190. *See* R. VEATCH, *supra* note 102, at 76.

191. *See* Note, *supra* note 36, at 298.

192. *See* Annas, *supra* note 94.

193. *Compare* Kennedy, *supra* note 173, at 446, *with* Bernat, Culver, & Gert, *supra* note 94.

194. *See supra* note 184.

195. *See* Annas, *supra* note 94.

196. *Id.*

197. *See* Gaylin, *supra* note 18.

198. One may attack this argument because it is based upon semantics. This is openly acknowledged. While the linguistics of the alternatives are different, the end result is still the same. But, due to its direct effect upon the evolution of social consciousness, language is a powerful force in society. Words have the ability to mold perceptions. Since morality is partially dependent upon perceptions, the semantic argument in favor of redefining death is a weighty one.

to create laws that govern society—would be a cherished one.¹⁹⁹

4. *Ethics Committees*

The New Jersey Supreme Court advised hospitals to develop committees that would review the physician's decision to disconnect a patient from a respirator.²⁰⁰ Since then a number of professional organizations²⁰¹ and scholars²⁰² have endorsed the use of ethical committees in medical decisionmaking. The ethics committee's role has evolved into a coadunation of advocate, counselor, educator, and judge with the primary objective of improving the ethical quality of medical decisions.²⁰³ The composition of the committee is a crucial factor in assuring the representation of a proper balance of interests.²⁰⁴ The American Academy of Pediatrics recommends that the committee should be composed of the following seven members to achieve such a balance: two physicians, one nurse, one hospital administrator, one lawyer, one ethicist or clergyman, and a lay person as community representative.²⁰⁵

Once the members are selected—preferably by an elected offi-

199. When faced with the precept that a cerebral definition of death would be inappropriate, perhaps on the theory that some thought processes may be deep brain or subcortical, see D. WALTON, *supra* note 19, at 84, other methods of decisionmaking may help ease the predicament. One solution would be to draft legislation approving active euthanasia for those in a vegetative state. See Williams, "Mercy-Killing" Legislation—A Rejoinder, 43 MINN. L. REV. 1 (1958) (arguing against the cruelty of refusing to allow one to die, and the lack of social interest to warrant this infringement upon the individual's freedom). Under an active euthanasia statute, the patient's demise would be more humane and less costly. Compassion would encourage a simple injection to end the patient's life rather than the time-consuming methods of starving or dehydrating the patient to death. But see Kamisar, *Some Non-Religious Views Against Proposed "Mercy Killing" Legislation*, 42 MINN. L. REV. 969 (1958) (arguing that active euthanasia, whatever its form, leads to moral degradation). Nevertheless, the adoption of an active euthanasia statute may be unrealistic in a state that does not accept a cerebral definition of death.

200. *In re Quinlan* 70 N.J. 10, 49-50, 355 A.2d 647, 668-69 (1976).

201. These organizations include the American Academy of Pediatrics (AAP), the National Association of Children's Hospitals and Related Institutions, the Association of American Medical Colleges, the Federation of American Hospitals, the American Hospital Association, and the National Perinatal Association. See Fleischman & Murry, *Ethics Committees for Infants Doe?*, 13 HASTINGS CENTER REP., Dec. 1983, at 5, 8.

202. *Id.* at 5. See also Randal, *Are Ethics Committees Alive and Well?*, 13 HASTINGS CENTER REP., Dec. 1983, at 10; Shapiro, *Medical Treatment of Defective Newborns: An Answer to the "Baby Doe" Dilemma*, 20 HARV. LEGIS. 137 (1983).

203. See Fleischman & Murry, *supra* note 201, at 8.

204. *Id.*

205. See Randal, *supra* note 202; Shapiro, *supra* note 202.

cial of the community²⁰⁶—the committee would be responsible for two tasks. The initial undertaking would be to conduct a prospective review of the attending physician's conclusions. The ethics committee would examine the prognosis, and then establish that there has been a clear flow of communication between the physician and his patient or the patient's guardian.²⁰⁷

The final phase of the prospective review is debatable. Upon reaching an ethical consensus, the committee may themselves make the decision of whether to withdraw the I.V. or "decide who should decide."²⁰⁸ Those who favor the latter position contend that "the job of ethics committees is to see that clearly wrong decisions are not permitted. They should be a check on bad decisions, not the primary deciders themselves."²⁰⁹

The propriety of withholding actual decisionmaking power from the ethics committee is questionable. Once it has reached a decision, it is illogically excessive to force the committee to select a party whose position embodies that decision rather than simply mandating the result itself. In fact, the procedure of "deciding who decides" these ethical and moral questions may be counterproductive. It diminishes the importance of each member's vote and fails to protect the individual decisionmaker from liability. Also, bureaucratic detachment toward the patient may result when the committee is so far removed from the consequences of its decision. Therefore, the ethics committee should conclude the prospective review by issuing a directive to the medical staff.

The final, although not entirely separate, duty of the ethics committee is that of retrospective review.²¹⁰ Such a review allows the committee to make *post hoc* determinations as to what could have been done better, and aids in establishing guidelines for the future. Of course, the ethics committee's decision may be challenged in

206. Most ethics committees today are institutional ethics committees (IECs), which operate within a single hospital. See Randal, *supra* note 202. However, a committee selection process that is accountable to the people is by far more preferable. A committee chosen by a hospital is likely to be dominated by members who weigh economic resources too heavily, and may do little to actually diffuse liability from the hospital. A selection system that is accountable to the public would be preferable since liability for the decision would be severed from the hospital, and, more importantly, the panel would embody the people's moral wisdom. This is no easy task, and the route to be taken would depend greatly upon the laws, population and needs of each particular community. Nevertheless, the medical and legal professions' ability to make such changes occur rapidly should not be doubted.

207. See Fleischman & Murry, *supra* note 201.

208. *Id.*

209. *Id.* at 9.

210. *Id.* at 8.

the courts and its liability is yet unknown.²¹¹ However, if the public was made responsible for the committee members' selection,²¹² it would be difficult to hold the members criminally liable, in the absence of extreme misconduct.

None of the arguments levied against the use of ethics committees seem to be insurmountable. Though the decisionmaking process of ethics committees may be slow and cumbersome, it is far more expedient than that of the court system and affords greater protection to the patient's right to privacy, since it draws less publicity than judicial proceedings.²¹³ Ethics committees are largely self-taught, which might lead to arbitrary decisions;²¹⁴ however, the recency of this issue and the relative lack of case law leaves any decisionmaking, whether it be by judge or doctor, open to the same attack. The process of retrospective review would continually supplement the committee's expertise through hindsight, leaving them in a far superior position to other decisionmakers.

Another objection to establishing the ethics committee as the primary decisionmaker is premised on the notion that the question involved is purely medical. It can be argued that, since the decision which must be made regarding the life or death of the patient hinges so critically upon medical determinations, the ethics committee is an inappropriate body of persons to be deciding the issue, and must be replaced by a prognosis board consisting solely of neurologists.²¹⁵ Although it is true that medical facts are critical to the decisionmaking process, equally important are the socio-philosophical ramifications of the decision. The dominance of the hospital and medical profession in addressing these more universal questions must be kept in check by the nonmedical members of the committee and those who appoint the committee members.

The final argument against vesting the ethics committees with absolute decisionmaking power is that such committees violate the patient's freedom of choice and dignity, and interfere with the physician's freedom to practice medicine. Arguably, the incompetent patient cares little about his freedom of choice and dignity; on the other hand, the ethics committee may actually help the competent patients who "find themselves browbeaten—by the hospital environment, their families' wishes, and the agendas of physicians—into accepting [or refusing] aggressive therapeutic measures

211. *Id.* at 9.

212. *See supra* note 206.

213. *See Randal, supra* note 202, at 10.

214. *Id.* at 12.

215. *See In re Colyer*, 99 Wash. 2d 114, ___, 660 P.2d 738, 749 (1983); Collester, *supra* note 144, at 320.

. . . ."²¹⁶ The patient's interests are further protected through the ethics committee's evaluation and disclosure of all medical options available to the patient. In addition, such committees could guarantee a greater degree of impartiality and uniformity than that offered by individual physicians. Finally, the ethics committees may actually promote the physician's freedom to practice medicine by relieving him of the burden of making these life and death decisions which are not fairly his to make and, thereby, diffusing the potential for criminal and civil liability.

IV. CONCLUSION

Recent technological advances in medicine have greatly aided the medical profession and society as a whole. Yet scientific progress has created perplexing situations that transcend the realm of medicine. The physician may unknowingly act beyond his domain as his role becomes increasingly uncertain. Such is the case when the physician withdraws nourishment and hydration from a living person. The blame for this unacceptable development cannot be cast upon the medical profession; it is a product of society's inability to symmetrically adapt to its rapidly changing world. The physician has labored enough under the constant spectre of malpractice litigation, professional sanctions, and personal conscience, to be burdened with a decision which may lead to criminal liability. However, relieving this burden by allowing the doctor, through omission, to dehydrate and starve a living, incurable patient through omission is clearly unsatisfactory. Such coldhearted selfishness and disregard for human life flies in the face of society's purpose, and constitutes an unbalanced leap onto that slippery slope to moral depravity.

The answer may be found within the meaning of the word "living." Recognition of a cerebral definition of death would relieve the physician of this burden, but adoption of the proper statute requires further debate and analysis. In most situations, the only immediate method of relieving the doctor's liability is through an ethics committee. However, the ethics committee must remember that when the question is solely one of whether to halt a "living" person's nourishment and hydration, the committee has no choice but to protect that life. In doing so, the values of society are embraced and reaffirmed.

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216. See Randal, *supra* note 202, at 12.